



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.uhcsr.com/geneva or by calling (800) 505-4160.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| What is the overall deductible? | Out of Network \$600 (Person) Preferred Providers \$200 (Person) Doesn't apply to preferred provider preventive care. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan documents to see if the deductible starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other deductibles for specific services? | Yes. Dental Pediatric \$500 , Medical Emergency Expenses \$150 Ded per visit, Urgent Care Center \$50 Ded per visit. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an out-of-pocket limit on my expenses? | Yes. Preferred Providers \$6,850 (Person) Out of Network \$15,000 (Person) Preferred Providers \$13,700 (Family) | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of preferred providers , see www.uhcsr.com/geneva or call (800) 505-4160. | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers . |
| Do I need a referral to see a specialist? | No. | You can see the specialist you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance (Coins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible (ded)**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Provider | Your Cost if You Use an Out of Network Provider | Limitations & Exceptions |
|--|--|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% Coins | 40% Coins | May not apply when related to surgery or Physiotherapy. |
| | Specialist visit | 20% Coins | 40% Coins | May not apply when related to surgery or Physiotherapy. |
| | Other practitioner office visit | 20% Coins | 40% Coins | —————none————— |
| | Preventive care/screening/immunization | No Charge | Not Covered | Includes preventive health services specified in the health care reform law or benefits provided as mandated by state law. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% Coins | 40% Coins | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% Coins | 40% Coins | —————none————— |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.uhcsr.com/pdl | Tier 1 - Your Lowest-Cost Option | \$15 Copay per prescription for Tier 1 | Not Covered | Preferred Providers: up to a 31 day supply per prescription Preferred Providers: (Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.) |
| | Tier 2 - Your Midrange-Cost Option | \$35 Copay per prescription for Tier 2 | Not Covered | You may need to obtain certain specialty drugs from a pharmacy designated by us. |
| | Tier 3 - Your Highest-Cost Option | \$60 Copay per prescription for Tier 3 | Not Covered | Preferred: (If a retail UnitedHealthcare |

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| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Provider | Your Cost if You Use an Out of Network Provider | Limitations & Exceptions |
|---|--|---|---|--|
| | Tier 4 - Additional High-Cost Option | Not Applicable | Not Applicable | Pharmacy offers to accept a price that is comparable to that of a mail order pharmacy, then up to a consecutive 90 day supply of a Prescription Drug Product at 2.5 times the Copay that applies to a 31 day supply per prescription.) |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coins | 40% Coins | _____none_____ |
| | Physician/surgeon fees | 20% Coins | 40% Coins | _____none_____ |
| If you need immediate medical attention | Emergency room services | 20% Coins \$150 Copay per visit | 20% Coins \$150 Ded per visit | May be limited to use of emergency room and supplies. Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Ded will be waived if admitted to the Hospital. |
| | Emergency medical transportation | 20% Coins | 20% Coins | _____none_____ |
| | Urgent care | 20% Coins \$50 Copay per visit | 40% Coins \$50 Ded per visit | May be limited to facility fees. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coins | 40% Coins | _____none_____ |
| | Physician/surgeon fee | 20% Coins | 40% Coins | _____none_____ |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% Coins | 40% Coins | _____none_____ |
| | Mental/Behavioral health inpatient services | 20% Coins | 40% Coins | _____none_____ |
| | Substance use disorder outpatient services | 20% Coins | 40% Coins | _____none_____ |
| | Substance use disorder inpatient services | 20% Coins | 40% Coins | _____none_____ |
| If you are pregnant | Prenatal and postnatal care | 20% Coins | 40% Coins | No cost share for preventive health services specified in the health care reform law when provided by a |

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| Common Medical Event | Services You May Need | Your Cost if You Use a Preferred Provider | Your Cost if You Use an Out of Network Provider | Limitations & Exceptions |
|---|-------------------------------------|--|---|---|
| | | | | Preferred Provider |
| | Delivery and all inpatient services | 20% Coins | 40% Coins | _____none_____ |
| If you need help recovering or have other special health needs | Home health care | 20% Coins | 40% Coins | _____none_____ |
| | Rehabilitation services | 20% Coins | 40% Coins | _____none_____ |
| | Habilitation services | 20% Coins | 40% Coins | _____none_____ |
| | Skilled nursing care | 20% Coins | 40% Coins | _____none_____ |
| | Durable medical equipment | 20% Coins | 20% Coins | _____none_____ |
| | Hospice service | 20% Coins | 40% Coins | _____none_____ |
| If your child needs dental or eye care | Eye exam | \$20 Copay | 50% Coins | See your plan's Pediatric Vision Benefit Details. Age limits apply. |
| | Glasses | Lens: \$40 Copay Frames: Tiered Copays from no charge to 40% based on retail cost. | 50% Coins | See your plan's Pediatric Vision Benefit Details. Age limits apply. |
| | Dental check-up | 50% Coins | 50% Coins | See your plan's Pediatric Dental Benefit Details. Age limits apply. |

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture except as noted in policy
- Dental care (Adult) except as noted in policy
- Long-term care
- Weight loss programs
- Bariatric surgery
- Hearing aids except as noted in policy
- Routine eye care (Adult) except as noted in policy
- Cosmetic surgery except as noted in policy
- Infertility treatment except as noted in policy
- Routine foot care except as noted in policy

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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Your Rights to Continue Coverage:

If you lose your status as an eligible student under your Student Health Insurance Coverage, Federal and State laws may allow you to continue your health coverage for a limited period of time. Any such rights will be limited in duration and will require you to pay a **premium**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the insurer at 1-800-767-0700. You may also contact your state insurance department at Pennsylvania Insurance Department at 1-877-881-6388 or visit <http://www.insurance.pa.gov>.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Pennsylvania Insurance Department at 1-877-881-6388 or visit <http://www.insurance.pa.gov>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-767-0700.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-767-0700.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-767-0700.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-767-0700.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,720
- Patient pays \$1,820

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$200 |
| Copays | \$20 |
| Coinsurance | \$1,400 |
| Limits or exclusions | \$200 |
| Total | \$1,820 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,120
- Patient pays \$1,280

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$200 |
| Copays | \$600 |
| Coinsurance | \$400 |
| Limits or exclusions | \$80 |
| Total | \$1,280 |

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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